GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Head and Neck Pathway Board

Head and Neck Pathway Board Meeting
Minutes and Actions

Meeting time and date: Wednesday 4th September 10:00-12:30

Venue: Manchester Airport Marriott Hotel, Hale Road, Hale Barns, Manchester, WA15 8XW

Members in attendance			
Name	**Role**	**Organisation/Representation**	**Attendance 2019/20**
David Thomson	Clinical Pathway Director	Greater Manchester Cancer	2/2
Rachel Allen	Pathway Manager	Greater Manchester Cancer	2/2
Richard Delleman	Patient Representative	NA	2/2
Stephen Sweeney	Patient Representative	NA	2/2
Jarrod Homer	Trust Representative	Manchester University NHS Foundation Trust - Oxford Road Campus	2/2
Rohit Kumar	Trust Representative	Manchester University NHS Foundation Trust - Wythenshawe, Trafford, Withington and Altrincham Campuses	2/2
Mazhar Iqbal	Trust Representative	Manchester University NHS Foundation Trust - Wythenshawe, Trafford, Withington and Altrincham Campuses	1/2
Panos Kyzas	Trust Representative	Pennine Acute Hospitals NHS Trust	2/2
Laxmi Ramamurthy	Trust Representative	Stockport NHS Foundation Trust	2/2
Tracey Ellis	Trust Representative	Tameside and Glossop Integrated Care NHS Foundation Trust	1/2
Rachel Hall	Histopathy Representative	Pennine Acute Hospitals NHS Trust	2/2
Yatin Jain	Radiology Representative	The Christie NHS Foundation Trust	1/2
Kate Garcez	Oncology Representative	The Christie NHS Foundation Trust	2/2
Carly Taylor	Dental Representative	Manchester University NHS Foundation Trust	2/2
Kerenza Graves	Nursing Representative	Bolton NHS Foundation Trust	1/2
Marie Round / Ruth Halford / Tracy Barnes	Nursing Representative	Pennine Acute Hospitals NHS Trust	2/2
Debbie Elliott	Nursing Representative	The Christie NHS Foundation Trust	1/2
Kathleen Mais	Nursing Representative	The Christie NHS Foundation Trust	2/2
Catherine Cameron	Nursing Representative	Wrightington, Wigan and Leigh NHS Foundation Trust	2/2
Frances Ascott	SLT Representative	Manchester University NHS Foundation Trust - Oxford Road Campus	2/2

Karen Livingstone	AHP Representative	GM Cancer	2/2
Ali Lewin	Commissioning Representative	GM Cancer	2/2
Michael Clinton	Living With and Beyond Cancer Representative	Macmillan	2/2
Marie Hosey	Cancer Managers Forum Representative	The Christie NHS Foundation Trust	1/2
Charlotte Finchett	Other Representative	The Christie NHS Foundation Trust	2/2

Guests in attendance		
Name	**Role**	**Organisation**
Alison Armstrong (AA)	Programme Lead	GM Cancer
Suzanne Lilley (SL)	Workforce Lead	GM Cancer
Clare Garnsey (CG)	GM Clinical Lead for Breast Cancer	GM Cancer
Lesley Gough (LG)	Consultant in Dental Public Health	PHE
Deborah Travis (DT)	Nursing Representative	Wrightington, Wigan and Leigh NHS Foundation Trust

Apologies			
Name	**Role**	**Organisation**	**Attendance 2019/20**
Natasha Smith (NS)	User Involvement Manager	Greater Manchester Cancer	1/2
Tony Bishop (TB)	Patient Representative	NA	0/2
Simon Hargreaves (SH)	Trust Representative	Bolton NHS Foundation Trust	0/2
Navin Mani (NM)	Trust Representative	Manchester University NHS Foundation Trust - Oxford Road Campus	1/2
Sean Loughran (SL)	Trust Representative	Salford Royal NHS Foundation Trust	0/2
Vijay Pothula (VP)	Trust Representative	Wrightington, Wigan and Leigh NHS Foundation Trust	0/2
Karen McEwan (KM)	Primary Care Representative	NA	1/2
Emma Currie (EC)	Nursing Representative	Manchester University NHS Foundation Trust - Wythenshawe, Trafford, Withington and Altrincham Campuses	1/2
Kate Hindley (KH) / Dawn Hulmes (DH)	Nursing Representative	Salford Royal NHS Foundation Trust	1/2
Amy Barker (AB) /	Dietetic Representative(s)	NA	1/2

Clare Roberts (CR) / Lorna Wilson (LW) / Laura McNeill (LM)			
Fiona Brennan (FB)	AHP Representative	The Christie NHS Foundation Trust	1/2
Susanna Durant (SD) / Louise Sloan (LS)	SLT Representative	Manchester University NHS Foundation Trust - Wythenshawe, Trafford, Withington and Altrincham Campuses	0/2
Robert Metcalf (RM)	Research Representative	The Christie NHS Foundation Trust	0/2
Richard Tipney (RT)	Other Representative	Pennine Acute Hospitals NHS Trust	1/2

1. Welcome and introductions	
Discussion summary	DT welcomed members and guests to the Pathway Board meeting. Apologies were noted. NM was thanked for his presentation at the HPV vaccination launch day on behalf of the Pathway Board which was very well received. It was highlighted that Anna Chittim, CNS from MFT is co-ordinating the Macmillan 'Basil Bus roadshow' in Manchester City Centre to raise awareness of the signs and symptoms of head and neck cancer. The event will be a collaborative effort between GM Cancer, MFT and Macmillan taking place on the 18th and 20th September. Pathway Board members are encouraged to get involved if interested. DT updated that RH has taken over leadership of the Living With & Beyond Cancer sub-committee in place of PB. It was noted that an issue around late referrals from head and neck impacting upon the haematology pathway at Pennine has been communicated by the GM Cancer Haem-Onc Pathway Board. PK commented that he is aware of the issue and action is being taken in house at Pennine.
Actions and responsibility	No further actions.

2. Board minutes and action tracker	
Discussion summary	The minutes of the June meeting were approved. It was noted that the action on lymphoedema is now closed (no. 45 on action tracker). An update was provided on the Prehab4Cancer project in terms of introducing the service to the head and neck cancer pathway. A senior registrar, James Price (JP) has been identified to lead on this, working with Dr John Moore (JM) and Zoe Merchant (ZM). It was highlighted that head and neck was not included in the first wave of pathways for the transformation

	funded project but JM and ZM are very keen to optimise head and neck cancer patients requiring treatment. AL informed the Board of discussions with Stockport following the last Pathway Board about the lack of neck lump clinic in Stockport. The issue has been raised at the Stockport Quality Review meeting. Following this meeting, Cath Comley (Stockport Commissioning Manager) has since updated that Stockport Foundation Trust are reviewing how they could streamline the pathway and are meeting with the Trust Executive Cancer Lead to discuss further. Conversations are ongoing. LR commented that some elements of a neck lump clinic are in place at Stockport such as adequacy checks. JH was invited to update on the Pathway Board's submission of proposals to the GM Digital Fund: one to support the thyroid MDT and the other, to support the mainstream head and neck MDT. The head and neck MDT proposal was produced in collaboration with the Christie digital and strategy team and was submitted in July. A decision on the outcome of the proposal is expected at the end of September 2019. DT thanked those involved in producing the proposals, particularly within the tight timescales set.
Actions and responsibility	**a) RA to upload the minutes to the website.**

3. Pathway Performance	
Discussion summary	MH provided a performance update for Q1 2019. GM as a whole is achieving 78% against a target of 85%. For Q1, the head and neck pathway achieved 81.86% against 85% (Q4 was 77%, Q3 was 72.2%). MH highlighted the main breach reasons for head and neck are complex pathways and internal diagnostic delays. These are the issues for most of the tumour groups. It was noted that 5 breaches were as a result of complex pathways, 9.5 were due to internal diagnostic delays i.e. radiology, histopathology/cytopathology reporting, EUA biopsies.
Actions and responsibility	No further actions.

4. Discussion and agreement of Head and Neck Best Timed Pathway for GM	
Discussion summary	RA highlighted that GM Cancer are expected to be in receipt of further investment from either Transformation Funding or investment from NHS England directly. DT/RA have been asked to develop a proposal around an accelerated pathway for head and neck cancer in GM. DT and RA have submitted an initial proposal to GM Cancer at the end of July which was a high level summary. The aim of the Pathway Board discussion is to gain clinical agreement for the best timed pathway in GM, a revised proposal will then be produced. Cancer Managers have been asked for their trust's workforce requirements in order to implement the pathway. A list of GM Cancer proposals is being shared in a paper at Cancer Board in September. An engagement event is planned for the 14th October, which Pathway Board members are invited to, along with wider stakeholders such as Director of Operations; Lead Cancer Clinicians, commissioners, GPs, plus others.

	DT clarified that other pathways received investment earlier in the year in Wave 1 to reform the pathway including lung, colorectal and prostate. The focus now is on gynae, head and neck and pancreatic cancer. The investment is essentially to pump-prime services and could include capital resource i.e. ultrasound kit and/or resource to fund key roles/personnel within trusts. SS queried what success has been witnessed so far in the lung, colorectal and prostate pathways that have received funding in Wave 1. AA clarified that the projects that have commenced have only just begun so it is too early to see any benefit in these pathways as posts are only just being filled in the trusts. A whole host of metrics have been developed in collaboration with commissioners, providers and PABC which will be monitored over time. DT summarised some of the elements that Board members may wish to consider. RK presented the proposed best timed pathway for the Board to consider. RK focused on the pathway for patients who present with a lateral neck lump. RK explained that the aspiration is for all patients to be diagnosed within 28 days of referral. RK spoke through the optimal pathway as follows: **Days 1-5:** *For those patients referred to a trust where there is a neck lump service available, they should be given a same day FNA and ideally an adequacy check, accepting that they won't necessarily receive a diagnosis on that day but the process is underway.* *Where there is a suspicion of cancer, patients will be given a diagnostic bundle which may include one or both of either cross-sectional imaging appropriate to the primary site of tumour, and an endoscopy or EUA biopsy if required..* It was noted that, for the optimal pathway, it is proposed that a diagnostic bundle is required at the point that the patient is first seen if there is a suspicion of cancer. They can be cancelled later if they are not required. Patients should be given the date and time of their scan(s) at that first appointment. **Days 6-14:** *Over the next week, the patient needs to have received their scans, had the scans reported, had cytology reported and if needed have a date or have undergone the EUA/biopsy.* **Days 15-18:** *By day 18, all tests should be completed.* **Days 19-25:** *Patients should be given the diagnosis by day 24 ideally, but ultimately clinicians have until day 28. If patients can be discussed in MDT by day 25, it is more likely that they will be treated within the 62 day target.* RK highlighted that from a patient journey perspective, continuity of care is ideal where patients are seen at every visit by the same clinicians. This may lead to delays due to

	logistical issues concerned with consultant clinic times etc. There is potential for patients to be seen by a team which would mean patients would see different consultants but the time between consultations is shortened, and so the anticipation of results is not prolonged. RD challenged the concept of continuity of care. From a patient perspective, it was commented that patients want to be seen in a quick and timely manner and would be happy to compromise seeing the same consultant if they could be seen more rapidly. SS commented that in an ideal world, the patient would be in control and would be given the option of seeing the same person with the knowledge that logistics in clinic times and availability of their consultant may lengthen their patient journey, or seeing multiple consultants and being seen more quickly. SS continued that an IT system, wrapped around this would give health professionals the ability to get up to speed on the patients history quickly and deliver the care, therefore it shouldn't matter that there isn't continuity of the consultant. Centralisation of resource was discussed and the notion of a central cancer tracker to move patients around the region where capacity exists in order to accelerate their pathway of care. RK clarified that the 28 day pathway is important as the quicker patients are diagnosed, the easier it is for patients to receive treatment within the 62 day pathway. RD queried whether the frequency of MDT meetings could be increased so that patients aren't left waiting for the next one each week. RK spoke of practice at Wythenshawe where patients are 'stepped off' the HSC pathway when investigations suggest non-cancer, and are transferred to an urgent pathway instead. Patients are still seen within a matter of weeks but the pressure on radiology and pathology is reduced. RK spoke through the results of an audit involving patients from over the past 2 years. The audit included patients who at the time of the initial consultation has no identifiable malignancy. None of these patients who ended up having a scan had any evidence of cancer which was reassuring. Pathologist and radiologists were asked to comment on the proposed turnaround times for pathology and radiology. RH commented that the pathology turnaround time of 3 days was very optimistic. RH commented on the processing and transport issues for cytopathology. 3 day turnaround would require a dedicated consultant who is only reporting urgent cases for an MDT. Pathologists on site when the neck lump clinics take place with reporting on the day (cytology reporting) was regarded as the optimal ideal standard. It was noted that this is the practice at Bolton. RH suggested a cytology turnaround time of a week. The lab manager within pathology is key to micromanaging the samples so that they are turned around within a given timeframe (not the Pathway Navigator). It was suggested for cytology reporting within a week YJ commented on the radiology component of the pathway. It was noted that there is no spare capacity within radiology throughout GM. Stepping patients off the HSC pathway who do not have cancer would help enormously. The radiology could be tailored for these

	patients, for example a scan with no contrast which is shorter could be used if there was a low index of suspicion. There was a suggestion around use of sonographer roles to support neck lump clinics who could be more ambulatory across multiple sites rather than an on-site sonographer. It would be easier for a sonographer to mobilise than a radiologist. There was an alternative suggestion for head and neck surgeons in each trust who can perform ultrasound. The concept of a centralised cytology centre was referenced as a sensible idea. There was support to explore centralisation of cytology reporting services to CMFT. This may improve efficiency, quality of reporting and 'free-up' regional pathologists' time to report histopathology. There would need to be consideration for who reviews for the MDT and presents it. A Biomedical Scientist (BMS) would be required in every centre. Lab management systems would need to interact. Histopathologists would then be freed up to report on biopsies. RK commented that the sequencing of events is important, not the timescales. For surgeons to undertake an EUA biopsy, the scan needs to have been performed in advance so that there are no artefacts on the scan after the biopsy. To achieve the optimal pathway set out, the biopsy has to have been done by day 15 and the scan has to have been in advance of that. RD commented that patients do not recognise borders between trusts so would be happy to travel wherever for testing and treatment. It was noted that some patients are less ambulatory and would struggle to travel. 7 day turnaround for radiology was considered acceptable. PK suggested that 5 days would be more aspirational. It was noted that pathology labs do not have the same ability to share information across trusts as radiology departments do with PACs. RK spoke through the proposed best timed pathway for worrying symptoms/primary site tumours. The only difference is that there is no requirement for ultrasound and FNA.
Actions and responsibility	No further actions.

5. Discussion summary and next steps	
Discussion summary	The Board agreed the pathway set out below:

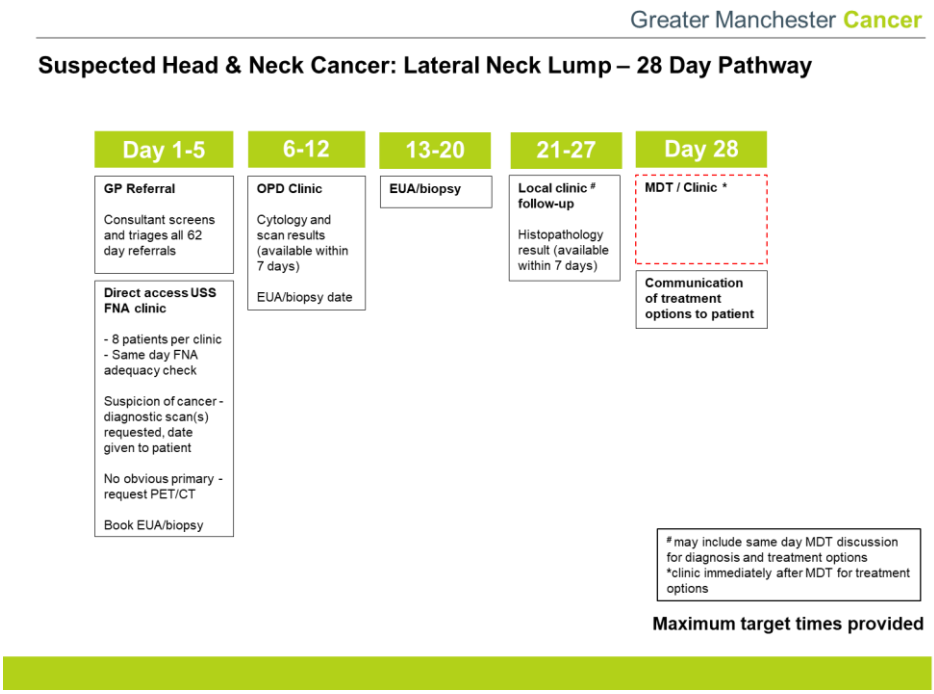

Figure 1. 28 day pathway for suspected head and neck cancer: presentation of lateral neck lump.

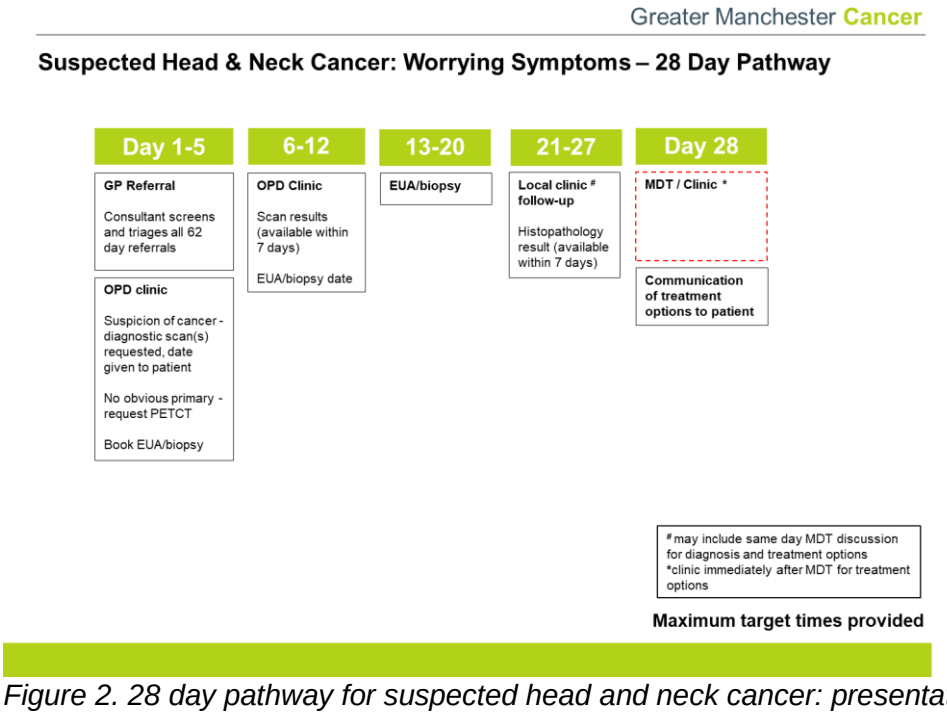

Figure 2. 28 day pathway for suspected head and neck cancer: presentation of worry symptoms.

	RK asked the Board whether any trusts were able to offer same day time slots (appointments) for their scans. MRI (MFT) have just started to implement this. Patients attend the neck lump clinic then go straight to radiology for their MR appointment. Reserved slots are dedicated for these patients. At Stockport, patients receive a direct booking form and are given a time there and then. SRFT have a similar offer. Trusts were asked for their comments against the agreed pathways (Figure 1 and Figure 2) and to comment on how their current pathway fits with this. A summary of this feedback is provided in appendix 1. RK requested further detailed information on the head and neck breaches within the banner of 'internal diagnostic delays'. It was noted that of the 466.5 breaches across GM, 21.5 were for head and neck in Q1. It was commented that pooled lists for EUA and biopsies would be an effective solution. Vetting of referrals was discussed. This should be done by Consultant staff. It was noted that MRI (MFT) vet all referrals within 2-3 hours of referral. RD commented that patients would like all references to 7 days changed to 1 day – 7 days is too long. RK suggested a minimum dataset for EUAs to report to a particular standard. There was a suggestion for a 'choose and book' system for cancer patients (similar to routine referrals) where the GP can offer patient choice about where the patient undergoes investigations and treatment, outlining the options available by proximity and waiting times. RA summarised the next steps with this work are to submit a revised proposal to GM Cancer. Board members were reminded of the 14th October Stakeholder Engagement Event which they are encouraged to attend.
Actions and responsibility	**a) MH to provide further detailed information on the head and neck breaches within the banner of 'internal diagnostic delays' for Q1.**

6. Education	
Discussion summary	KM updated the board on the Inaugural GM Cancer Head and Neck Symposium which has been confirmed for the 6th November 2019. Approximately 100 delegates are registered to attend to so far.
Actions and responsibility	**a) All to share invitation with their networks.**

7. AOB

Discussion summary	NA.
Actions and responsibility	**NA**

Future meetings:

Friday 17th January 2020, 10:00-12:30, Manchester Airport Marriott Hotel, Hale Road, Hale Barns, Manchester, WA15 8XW